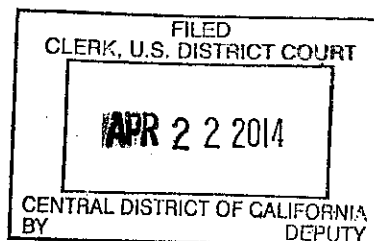


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CLERK U.S. DISTRICT COURT  
CENTRAL DIST. OF CALIF.  
LOS ANGELES



UNITED STATES DISTRICT COURT  
FOR THE CENTRAL DISTRICT OF CALIFORNIA

CRT 4-0231

UNITED STATES OF AMERICA, ) CR No.  
Plaintiff, ) INFORMATION  
v. ) [18 U.S.C. § 1349: Conspiracy  
JASON C. LING, ) to Commit Health Care Fraud]  
Defendant. )

The United States Attorney charges:

[18 U.S.C. § 1349]

A. INTRODUCTORY ALLEGATIONS

At all times relevant to this Information:

The Conspirators

1. Defendant JASON C. LING ("LING") was a physician licensed to practice medicine in the State of California, who operated a medical clinic located at 9430 Crest Drive, Spring Valley, California.

2. Co-conspirator E.O. was the owner and operator of a durable medical equipment ("DME") company in Los Angeles, California.

///

1        The Medicare Program

2        3.     Medicare was a federal health care benefit program,  
3     affecting commerce, that provided benefits to individuals who  
4     were over the age of 65 or disabled. Medicare was administered  
5     by the Centers for Medicare and Medicaid Services ("CMS"), a  
6     federal agency under the United States Department of Health and  
7     Human Services ("HHS").

8        4.     CMS contracted with private insurance companies to (a)  
9     certify DME providers for participation in Medicare and monitor  
10    their compliance with Medicare standards; (b) process and pay  
11    claims; and (c) perform program safeguard functions, such as  
12    identifying and reviewing suspect claims.

13       5.     Individuals who qualified for Medicare benefits were  
14    referred to as Medicare beneficiaries. Each Medicare beneficiary  
15    was given a Health Identification Card containing a unique  
16    identification number ("HICN").

17       6.     DME companies, physicians, and other health care  
18    providers that provided medical services that were reimbursed by  
19    Medicare were referred to as Medicare "providers."

20       7.     To obtain payment from Medicare, a DME company first  
21    had to apply for and obtain a provider number. By signing the  
22    provider application, the DME company agreed to abide by Medicare  
23    rules and regulations, including the Anti-Kickback Statute (42  
24    U.S.C. § 1320a-7b(b)), which, among other things, prohibited the  
25    payment of kickbacks or bribes for the referral of Medicare  
26    beneficiaries for any item or service for which payment may be  
27    made by the Medicare program.

1        8.    If Medicare approved a provider's application, Medicare  
2 assigned the provider a Medicare provider number, enabling the  
3 provider (such as a DME company or physician) to submit claims to  
4 Medicare for services and supplies provided to Medicare  
5 beneficiaries.

6        9.    To obtain and maintain their Medicare provider numbers  
7 and billing privileges, DME suppliers had to meet Medicare  
8 standards for participation. The Medicare contractor responsible  
9 for evaluating and certifying DME suppliers' compliance with  
10 these standards was Palmetto GBA ("Palmetto").

11       10.   From in or about October 2006 through the date of this  
12 Information, Noridian Administrative Services ("Noridian")  
13 processed and paid Medicare DME claims in Southern California.

14       11.   Most Medicare providers, including the company owned  
15 and operated by co-conspirator E.O., submitted their claims  
16 electronically pursuant to an agreement with Medicare that they  
17 would submit claims that were accurate, complete, and truthful.

18       12.   Medicare paid DME providers only for DME that was  
19 medically necessary to the treatment of a beneficiary's illness  
20 or injury, was prescribed by a beneficiary's physician, and was  
21 provided in accordance with Medicare regulations and guidelines  
22 that governed whether a particular item or service would be paid  
23 by Medicare.

24       13.   To bill Medicare for DME provided to a beneficiary, a  
25 DME supplier was required to submit a claim (Form 1500).  
26 Medicare required claims to be truthful, complete, and not  
27 misleading. In addition, when a claim was submitted, the DME  
28

1 provider was required to certify that the DME or services covered  
2 by the claim were medically necessary.

3 14. Medicare required a claim for payment to set forth,  
4 among other things, the beneficiary's name and HICN, the type of  
5 DME provided to the beneficiary, the date the DME was provided,  
6 and the name and unique physician identification number ("UPIN")  
7 of the physician who prescribed or ordered the DME.

8 15. Medicare had a co-payment requirement for DME.  
9 Medicare reimbursed providers 80% of the allowed amount of a DME  
10 claim and the beneficiary was ordinarily obligated to pay the  
11 remaining 20%.

12 16. Defendant LING wrote medically unnecessary  
13 prescriptions for power wheelchairs ("PWCs") and related  
14 accessories that co-conspirator E.O. used as the basis to submit  
15 false and fraudulent claims to Medicare.

16 17. Between in or around March 2010 and in or around  
17 November 2010, co-conspirator E.O. submitted, or caused to be  
18 submitted, to Medicare claims totaling approximately \$496,794 for  
19 purported PWCs and other DME based on medically unnecessary  
20 prescriptions and other documents written by defendant LING, and  
21 Medicare paid approximately \$311,145 on those claims.

22 B. THE OBJECT OF THE CONSPIRACY

23 18. Beginning in or around March 2010, and continuing  
24 through in or around November 2010, in Los Angeles County, within  
25 the Central District of California, and elsewhere, defendant  
26 LING, together with co-conspirator E.O. and others known and  
27 unknown to the United States Attorney, knowingly combined,  
28

1 conspired, and agreed to commit health care fraud, in violation  
2 of Title 18, United States Code, Section 1347.

3 C. THE MANNER AND MEANS OF THE CONSPIRACY

4 19. The object of the conspiracy was carried out, and to be  
5 carried out, in substance, as follows:

6 a. Defendant LING would use street-level marketers to  
7 unlawfully recruit Medicare beneficiaries to obtain PWCs and  
8 other DME that the beneficiaries did not need.

9 b. The marketers would take the Medicare  
10 beneficiaries to visit defendant LING, and defendant LING would  
11 write prescriptions for PWCs and other DME that he knew the  
12 beneficiaries did not need.

13 c. Defendant LING would provide the prescriptions and  
14 other supporting documents to marketers and others knowing that  
15 the prescriptions and documents would be provided to a DME  
16 company in Los Angeles, California, owned by co-conspirator E.O.,  
17 and knowing that the prescriptions and documents would be used to  
18 submit false and fraudulent claims to Medicare.

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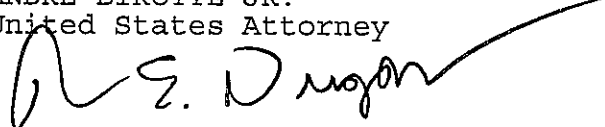
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1           d.    After acquiring the false and fraudulent  
2 prescriptions and supporting documents written by defendant LING,  
3 co-conspirator E.O. would submit, or cause the submission of,  
4 false and fraudulent claims to Medicare for medically unnecessary  
5 PWCs and other DME.

6  
7           ANDRÉ BIROTTE JR.  
8           United States Attorney  
9           

10          ROBERT E. DUGDALE  
11          Assistant United States Attorney  
12          Chief, Criminal Division

13          RICHARD E. ROBINSON  
14          Assistant United States Attorney  
15          Chief, Major Frauds Section

16          CONSUELO WOODHEAD  
17          Assistant United States Attorney  
18          Deputy Chief, Major Frauds Section

19          BEN CURTIS  
20          Assistant Chief, Fraud Section  
21          United States Department of Justice

22          ALEXANDER F. PORTER  
23          Trial Attorney, Fraud Section  
24          United States Department of Justice  
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26  
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